



**SPINE AND SPORTS
REHABILITATION CENTER**
PHYSICAL THERAPY

The purpose of this questionnaire is to help us understand your health status. Please complete this form and your therapist will answer any questions during your exam. This form is considered part of your medical record. PATIENT NAME: _____

1. Have you ever suffered from or been told that you have:	Therapist's Comments:
High blood pressure	yes / no
Heart problems	yes / no
Lung problems	yes / no
Kidney problems	yes / no
Head injury	yes / no
Multiple Sclerosis / Parkinson's Disease	yes / no
Stroke / Neurological problems	yes / no
Liver problems	yes / no
Thyroid problems	yes / no
Blood disorders	yes / no
Diabetes (high blood sugar)	yes / no
Low blood sugar	yes / no
Seizure	yes / no
Cancer	yes / no
Arthritis	yes / no
Tuberculosis	yes / no
Repeated infections	yes / no
Osteoporosis	yes / no
Circulation or vascular problems	yes / no
Broken bones (fractures)	yes / no
Ulcers / stomach problems	yes / no
FOR MEN ONLY:	
Prostate disease	yes / no
FOR WOMEN ONLY:	
Pelvic inflammatory disease	yes / no
Endometriosis	yes / no
Have you had complicated pregnancies or deliveries	yes / no
Trouble with your period	yes / no
Are you pregnant, or think you might be pregnant	yes / no
2. Have you recently had:	
Weight loss / gain	yes / no
Loss of appetite	yes / no
Unexplained fever or chills	yes / no
Pain at night	yes / no
Fatigue / tiredness or malaise	yes / no
Difficulty sleeping	yes / no

Joint pain and/or swelling	yes / no	
Urinary or bowel problems	yes / no	
Nausea and vomiting	yes / no	
Numbness or tingling	yes / no	
Weakness in your arms or legs	yes / no	
Coordination problems	yes / no	
Difficulty walking	yes / no	
Dizziness or loss of consciousness	yes / no	
Loss of balance	yes / no	
Chest pain	yes / no	
Heart palpitations	yes / no	
Shortness of breath	yes / no	
Difficulty swallowing	yes / no	
New onset of headaches	yes / no	
Visual problems	yes / no	
Hearing problems	yes / no	
Hoarseness	yes / no	
Cough	yes / no	
3. Do you		
Smoke	yes / no	
- If yes, how much? _____ ppd		
Have any significant family history of illness or disease	yes / no	
Have any other medical problems	yes / no	THERAPISTS SIGNATURE
		DATE
4. Have you had surgery or been hospitalized in the past?	YES / NO	If yes , please list below:
a.	Reason:	Date:
b.	Reason:	Date:
c.	Reason:	Date:
5. Who is your primary doctor, or the doctor you see most often?		
6. When was your last general health check-up?	Date: _____	
7. When is your next appointment with your doctor that referred you to physical therapy?	Date _____	
<p>I understand that I am responsible for knowing my insurance coverage for physical therapy services, and I understand that my insurance may have coverage limitations. Under these conditions, I understand that I am responsible to pay for all services rendered. I also authorize the release of information requested on forms submitted in my behalf. I further understand that information so released may be redisclosed and no longer be protected as provided in CRF 164.508 (c)(2)(iii).</p>		
<p>_____</p> <p>PATIENT'S SIGNATURE</p>		<p>_____</p> <p>DATE</p>